APPLICATION FOR APPROVAL OF EDUCATION
FOR COMPULSIVE GAMBLING COUNSELORS
Training Provider/Sponsor Form

Training Provider/Sponsor: _____

Address: _____
(Street / P.O. Box) (City/State/Zip)

Provider Representative
Completing Application: _____ Telephone: (_____) _____

1. Program Title: _____

2. Program Date(s):
(Include All)

(a) _____

(b) _____

3. Program Location(s):
(City, State)

(a) _____

(b) _____

4. To which education domain(s) does this training apply (check all that apply)

	DOMAIN	**HOURS REQUESTED**
[ ]	Intake and Assessment	_____
[ ]	General Knowledge	_____
[ ]	Significant Others	_____
[ ]	Case Management	_____
[ ]	Individual Group Counseling	_____
[ ]	Special Populations	_____
[ ]	Legal / Financial	_____

Signature: _____ Date: _____

Mail completed form with attachments to Education Review, ATTN: CCGC Certification,
Office of Mental Health, Substance Abuse and Addiction Services,
P.O. Box 98925, Lincoln, NE 68509-8925.

For Office Use Only

The above training is: Approved [ ] Denied [ ]

Hours Approved: _____ Approval Number: _____

Reason for Denial: _____

_____

Office Authority _____ Date _____